TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PRC HEALTH SERVICES

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-16-3377-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has made several attempts to obtain reimbursement for services authorized by the carrier on the above mentioned patient."

Amount in Dispute: $5,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has paid an additional $5,875.00 for the above dates of service for a total of $6,975.00."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2016 through March 30, 2016	CPT Code 97799-CP (61 hours) Chronic Pain Management Program	$5,000.00	$4,400.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- Payment is 80 percent of the AMR for a CARF-accredited program. Documentation of CARF-accreditation of the program must be provided.

Issues

Is the requestor entitled to additional reimbursement for chronic pain management program?

Findings

The requestor billed CPT code 97799-CP for a non-CARF accredited chronic pain management program.

28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs:

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

On August 30, 2016, the division contacted the requestor's representative Anna Hernandez to verify that services remained in dispute. Ms. Hernandez stated that for the dates of service in dispute, the respondent had made an additional payment of $500.00 for date of service March 21, 2016.

The Division finds that the requestor billed CPT code 97799-CP for 61 hours. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the 61 hours documented is $6,100.00. The respondent paid $1,700.00. The Division finds the requestor is due additional reimbursement of $4,400.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,400.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,400.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		08/31/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.